

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of \$129.90 for date of service 04/27/01.
- b. The request was received on 03/18/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60
 - b. HCFA(s)
 - c. TWCC 62 forms
 - d. Reimbursement data
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Response to a Request for Dispute Resolution
 - b. HCFA(s)
 - c. TWCC 62/EOB
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/23/02. Per Rule 133.307 (g) (4)(5), the carrier representative signed for the copy on 04/24/01. The response from the insurance carrier was received in the Division on 05/02/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

“The expected out come of this issue is that we feel the claims should be paid in full, according to the established fair and reasonable guideline.”

2. Respondent:

“The carrier paid a fair and reasonable amount for \$50.00 for the large hot/cold pack. As the code E1399 is an unlisted, d.o.p. code, the carrier paid a usual and reasonable amount for this service.”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 04/27/01.
2. The denial listed on the EOB is “M-REDUCED TO FAIR AND REASONABLE. F-REIMBURSEMENT FOR YOUR RESUBMITTED INVOICE HAS BEEN CONSIDERED BASED ON USUAL, CUSTOMARY AND REASONABLE CHARGES FOR PROVIDERS IN YOUR GEOGRAPHIC (ZIP CODE) AREA. NO ADDITIONAL MONIES ARE BEING PAID AT THIS TIME.”
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
04/27/01	E1399 (ALT. H/C NON-ELEC LOW BACK- LG)	\$179.90	\$50.00	F,M	DOP	TWCC Sec. 413.011(d) MFG DME; (X)(C) MFG GI; (III)(VI)	“CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate.” The provider’s only evidence of fair and reasonable are EOBs from other insurance carriers. MFG GI(III) places the burden on the provider to prove that the amount of reimbursement requested is fair and reasonable. The provider has submitted EOBs to document fair and reasonable reimbursement. In light of recent SOAH decisions, where providers had submitted EOBs for fair and reasonable, SOAH has placed minimal value on EOBs for documenting fair and reasonable. Therefore, additional reimbursement is not recommended.
Totals		\$179.90	\$50.00				The Requestor is not entitled to reimbursement.

This above Findings and Decision is hereby issued this 9th day of July 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.